

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2016
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/16/2016 |
| NAME OF PROVIDER OR SUPPLIER ADAMS HERITAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 000 | <p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/16/16</p> <p>Facility Number: 002549 Provider Number: 155729 AIM Number: 200289420</p> <p>At this Life Safety Code survey, Adams Heritage was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 61 and had a census of 45 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were a detached shed used for storage of maintenance equipment, parts and the facility's bus and another detached shed used for storage of maintenance supplies.</p> <p>Quality Review completed on 08/18/16 - DA</p> | K 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2016
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/16/2016 |
| NAME OF PROVIDER OR SUPPLIER ADAMS HERITAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | | |